Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
II 6045473				C 01/16/2025		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE						
ILLINOIS VETERANS HOME AT QUINCY  1707 NORTH 12TH STREET QUINCY, IL 62301						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Facility Reported Incident of 1/8/25- IL183992					
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	340.1505a) 340.1505b)3)					
	Section 340.1505 Restorative Service	Medical, Nursing and es				
	a) Comprehensive resident care plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.					
	and services to atta practicable physica well-being of the re each resident's cor plan. Adequate and care shall be provide	provide the necessary care ain or maintain the highest I, mental, and psychosocial sident, in accordance with aprehensive resident care I properly supervised nursing led to each resident to meet re needs of the resident.				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

PRINTED: 02/19/2025 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
IL6015473		B. WING			C <b>01/16/2025</b>	
NAME OF				TATE TIP CODE	1 0	10,2020
NAME OF	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
ILLINOIS	VETERANS HOME A	T QUINCY	RTH 12TH ST , IL  62301	REEI		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	resident's condition emotional changes determining care re further medical eva	rations of changes in a s, including mental and , as a means for analyzing and equired and the need for luation and treatment shall be aff and recorded in the record.	i			
	These regulations a	are not met as evidence by:				
	Based on Interview and Record review, the facility failed to develop a care plan for droplet isolation and a new diagnosis of infectious Covid-19 for two of three residents (R1, R2) reviewed for Covid-19 in the sample of three.					
	Findings include:					
	documents "Policy: interdisciplinary app baseline plan of car healthcare informat resident, including based on admission assist the resident i optimal level of fundadmission in the Elfollowed by the dev Comprehensive car RAI-Resident Assed driven by not only the problems, but also characteristics, streand preferences. R transfers will require Comprehensive Car	proach to resident's care, a re (including minimum ion to take care of the out not limited to initial goals in orders will be formulated to in achieving his/her goals and ctioning within 24 hours of HR (electronic health record) elopment of the re plan (the final step in the ssment Instrument process), ne identified resident by a resident's unique engths, weaknesses, needs, eadmissions and unit to unit				

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		(X1) PROVIDER/SUPPI IDENTIFICATION N		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	IL6015473		B. WING			C <b>16/2025</b>			
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
ILLINOIS	ILLINOIS VETERANS HOME AT QUINCY  1707 NORTH 12TH STREET								
QUINCY, IL									
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
S9999	Continued From page 2		S9999						
	care." This same p effectiveness of the and modified as ne change is made in a changes to the care in accordance with practice of docume be done by any me team."	olicy documents "I care plan must be cessary in the EHF the resident's care. e plan should occur professional standantation. These cha mber to the interdis	evaluated I, anytime a These as needed ards and anges can sciplinary						
	<ol> <li>R1's Nursing Progress Notes, dated 12/27/24, document R1 tested positive for Covid-19 virus and R1 was moved to the facility's Covid-19 unit for isolation and treatment.</li> <li>R1's current care plan, dated 1/15/25, does not document an active or resolved plan of care to address R1's recent Covid-19 infection.</li> <li>R2's Nursing Progress Notes, dated 12/31/24, documents R2 tested positive for Covid-19 virus and R2 was transferred to the facility's Covid-19 unit for treatment.</li> </ol>								
	R2's Nursing Progres 3:43 AM, document local hospital and the intensive care unit foovid-19.	s R2 was transferr nen admitted to the	ed to the hospital's						
	R2's current care pl document an active address R2's Covid	or resolved plan o							
	On 1/15/25 at 2:20 Minimum Data Set R2 both reside in th V5 stated "I do the residents who resid update the resident	coordinator) confiri e facility's Markwa quarterly care plan e in Markward. Nu	med R1 and rd building. s for irsing can						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			COMPLETED			
					С			
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S9999	acute that happens assessments. So, admitted to the Covresult, the nurse we for updating the car (R1 and R2's) care either were updated Covid-19 and began monitoring for the il	ge 3 between those quarterly when (R1 and R2) were rid-19 unit with a positive orking the floor at that time in buld be the one responsible re plan. I looked through both plans and do not see where d when they tested positive for n isolation, treatment and lness. The care plans should to include a plan of care for	S9999					

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